

**Pediatric Death Supplemental Form**

(To be completed in conjunction with the Pediatric Severe Influenza Case History Form)

Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Was an autopsy performed?

☐ Yes ☐ No

If yes, please attach autopsy report, if available

Location of death: ☐ Home ☐ Emergency Dept (ER) ☐ Inpatient ward ☐ ICU  
☐ Other (specify): \_\_\_\_\_**Influenza Testing (check all tests that were performed):**☐ Commercial rapid antigen test**Results:**☐ Influenza A ☐ Influenza B ☐ Negative☐ Influenza A/B (Not Distinguished)

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Viral culture**Results:**☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Direct fluorescent antibody (DFA)**Results:**☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Indirect fluorescent antibody (IFA)**Results:**☐ Influenza A ☐ Influenza B ☐ Negative ☐ Influenza A/B

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Enzyme immunoassay (EIA)**Results:**☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ RT-PCR**Results:**☐ Influenza A (Subtyping Not Done) ☐ Influenza B ☐ Negative☐ Influenza A (Unable To Subtype) ☐ Influenza A (H1) ☐ Influenza A (H3)

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Immunohistochemistry (IHC)**Results:**☐ Influenza A ☐ Influenza B ☐ Negative

Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Was an INVASIVE bacterial infection confirmed by culturing an organism from a specimen collected from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid)?**☐ Yes **If yes, specify:** ☐ No

|   |   |   |
|---|---|---|
| <input type="checkbox"/> <i>Streptococcus pneumoniae</i>          | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>sensitive</b>        | <input type="checkbox"/> <i>Neisseria meningitidis</i> (serogroup, if known): _____ |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> type b     | <input type="checkbox"/> <i>Staphylococcus aureus</i> , methicillin <b>resistant</b> (MRSA) | <input type="checkbox"/> Group A streptococcus: _____                               |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> not-type b | <input type="checkbox"/> <i>Staphylococcus aureus</i> , <b>sensitivity not done</b>         | <input type="checkbox"/> Other invasive bacteria: _____                             |

**TO REPORT A CASE, PLEASE CALL SAN DIEGO COUNTY COMMUNITY EPIDEMIOLOGY DIVISION AT 619-515-6620, AND  
FAX THIS FORM TO: (619) 515-6644.**

For questions, contact your local county health department or the California Department of Health Services Immunization Branch [Janice Louie, MD or Trevor Shoemaker, MPH at 510-540-2065]